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Health Carrier Provider Denial Letter

Nevada Revised Statute (NRS) 679B.124 requires the Commissioner of Insurance to develop, prescribe, and make available a form letter that a health carrier must use to notify a provider of health care[1] of the denial of the application to be included in the carrier's network of providers. Carriers should use the following guidance to comply with NRS 679B.124 section 2.

1. **Carriers must use the provider denial letter developed by the Commissioner of Insurance, which is available on the Division of Insurance website.** The form letter is available at http://doi.nv.gov/Insurers/Life-Health/Required-Industry-Reports/. The provider denial letter may be printed on the carrier's letterhead but must be substantially the same as the form letter developed by the Commissioner. Adjustments may be made to accommodate provider groups, but must include the following information at minimum:
   a) The name of each individual provider and the corresponding National Provider Identifier (NPI)
   b) The address of the provider
   c) The specialty or specialties of each provider
   d) The specific reason(s) for the denial
   e) Contact information for appeals and/or the provider relations department
   f) The provider's appeals status, e.g. appeal available, appeals exhausted, etc.]

2. **Carriers must submit copies of the provider denial letters to the Commissioner via the System for Electronic Rate and Form Filing (SERFF).**
   Section 2 of NRS 679B.124 states "a health carrier shall submit to the Commissioner a copy of each form letter sent to a provider of health care pursuant to section 1 at the same time the letter is sent to the provider of health care." The copies must be submitted to the Commissioner through SERFF under the

[1] "Provider of health care" is defined in NRS 687B.660, NRS 694G.070, and NRS 686A.2825.

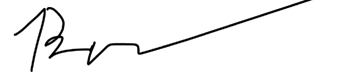
Type of Insurance (TOI) – *Required Industry Reports - Insurers* and the Sub-TOI *Provider of Health Care Denial Letter*. A copy of the denial letter should be submitted under the supporting document tab in SERFF.

3. **Entities required to comply with the provisions in NRS 679B.124, section 2.**
   Any carrier that offers a network plan as defined by NRS 689B.750 must comply with the provisions of the bill. These provisions do not apply to pharmacy benefit managers (PBMs), independent physician associations (IPAs), and third-party administrators that maintain a private network.

4. **Frequency of Submission of Denial Letters.**
   The statute requires a carrier to submit a copy of the denial letter at a frequency determined by the Commissioner. While the Division determines the appropriate frequency for submissions, submissions should be submitted no less than once a month. The submission should include a spreadsheet which includes all the information listed in section 1 of this bulletin and the date the letter was sent to the provider for all provider denial letters sent for the reporting period. The carrier is responsible for maintaining a copy of the provider denial letter which must be provided to the Commissioner upon request.

5. **Timeliness of Submission of Denial Letters.**
   A carrier must submit the initial denial letter, in addition to a final denial letter issued if the matter is appealed.

Questions concerning NRS 679B.124 or this bulletin can be directed to the Life and Health staff in the Product Compliance section of the Division of Insurance, at (775) 687-0729 or insinfo@doi.nv.gov.



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